Exhibit 3

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION FILE NO. 1:23-CV-480

PLANNED PARENTHOOD SOUTH ATLANTIC, et al.,

Plaintiffs,

vs.

JOSHUA STEIN, et al.,

Defendants

and

PHILIP E. BERGER and TIMOTHY K. MOORE,

Intervenor-Defendants

VIDEO CONFERENCE DEPOSITION OF CHRISTY MARIE BORAAS ALSLEBEN, MD

TAKEN VIA VIDEO CONFERENCE AT THE OFFICES OF:
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08-29-2023
10:06 O'CLOCK A.M.

Gretchen Wells
Court Reporter

Parenthood North Central States and I also serve as one of the associate medical directors. I am not the chief medical officer of Planned Parenthood North Central States.

Q. Do you know Dr. Farris personally?

A. I don't.

Q. Never met her at any Planned Parenthood convention or seminar or anything like that?

A. I have never met her directly.

Q. Excluding the lawyers who represent the Plaintiffs in this case, have you spoken to anyone else, to include other doctors perhaps, about your opinions in this case?

A. No. I mean, my husband knows I'm here, but he -- he's not medical and he wouldn't know anything I was speaking about if I tried to tell him.

Q. So you said you looked at Senate Bill 20 in the process of developing your opinions. Did you see where it defines possible complications that can arise from an induced abortion at North Carolina General Statue Section 90-21.81(2)a?

A. I mean, I'd have to see the text again to say whether or not I reviewed that portion.

Q. Okay. What is a uterine perforation?

A. A uterine perforation is a known risk of

procedural abortion when an instrument goes into the wall or through the wall of the uterus during the procedure.

Q. When you say "instrument," what do you mean by instrument?

A. A surgical instrument, either a suction cannula or a forceps, typically.

Q. And how does that happen during a procedural -- I'm sorry, surgical abortion?

A. How that happens, you know, really just depends on the -- on the case. It is a very low risk. It's a very -- it's a -- it's a known complication and one that I counsel patients about, but it is not very common.

Q. Do you agree that this is a possible complication that can arise from an induced abortion, surgical abortion, that should be disclosed to a pregnant woman who is a patient considering that type of abortion so that the patient can make an informed decision with more complete knowledge of the risks of the procedure?

MS. GRANDIN: Objection to form.

THE WITNESS: I believe all people should -- that are pregnant and considering abortion should be counseled on the risks and benefits of the

desired mode of abortion that they are considering.

Q. (Mr. Boyle) And who should inform the patient of that potential risk?

A. I mean, our whole healthcare team takes onus of that. But ultimately, it's my responsibility as the treating physician to ensure that the patient has good informed consent about the procedure that they have selected.

Q. And how -- I'm sorry, when should that patient be informed of this particular risk?

A. Prior to their procedural abortion.

Q. Are you aware that in -- under the North Carolina law, there's a 72-hour informed consent period where, after the initial counseling, the patient has to wait 72 hours before the induced abortion can occur?

A. I was not -- I'm -- I was not aware of that mandatory counseling wait, but that is a common thing that -- law that some patient -- some states have enacted accepting and exceptionalizing the healthcare that we provide during abortion care.

Q. What is a cervical laceration?

A. A cervical laceration is a tear that -- in the cervix.

Q. And how -- well, do you agree that a

I think that's an intense word for what we're doing.

But I -- to, you know, get back to your question, if that's what we're defining as curettage, then I -- the last time I needed to use that in the setting of a procedural abortion was -- I don't know. It happens extremely rarely.

Q. (Mr. Boyle) Okay. With the D&E abortion, after you have used the forceps to grasp and guide the bigger portions of the fetus or baby out of the uterus, what do you do after you -- you're done with the forceps portion of the procedure?

A. Yeah, so once I'm confident that we have, you know, nearly all the products of conception evacuated safely from the uterus, then I would advance a suction cannula to the fundus of the uterus, or the top, and aspirate any remaining decidual tissue, typically, that still remains within the uterus.

Q. When you say, "the fundus," or the top, that's the part farthest away from the cervix, so sort of up towards the rib cage and the lungs, that direction of the body?

A. Yeah. I guess. It's the portion of the uterus typically the furthest away both from me as the operator, as the surgeon and, as you described, from the cervix, yes.

Q. Is there anything else about the D&E abortion procedure that you do that we didn't cover or that we've missed?

MS. GRANDIN: Objection to form.

THE WITNESS: As far as the procedural steps?

Q. (Mr. Boyle) Yes. The start to finish, how it -- how it actually unfolds and your process.

A. Yeah, I mean, for every procedure, we would start with a surgical timeout and make sure that the healthcare team, you know, was all on the same page and prepped and ready for the procedure that we planned. We discuss, you know, the patient's wishes, any allergies, planned anesthesia, type of specimen we will have at the end. You know, we do many things.

But if you're talking about the procedure, you know, the actual operating steps for me as surgeon, then we've described those pretty much in detail. The main last one is, you know, assessment of hemostasis and ensuring that bleeding is appropriate.

Q. You mentioned anesthesia. What type of anesthesia options are available for your patients who you are performing a D&E abortion on?

MS. GRANDIN: Objection to form.

THE WITNESS: The patients that I see

have a -- a very wide range of anesthesia options.

Q. (Mr. Boyle) Such as?

A. Such as it is standard practice to ---

Q. Go ahead and drink water. I didn't mean to interrupt you. I'm sorry.

A. Oh, that's okay.

Q. Take your time.

A. I got this one.

Q. Okay.

A. The standard practice, to use local anesthesia by the cervix for all patients unless, for example, a patient has a severe allergy. From there, patients can opt for mild sedation with medicine or moderate sedation with medicine, deep sedation with medicine or a general anesthesia.

Q. So local anesthesia, what's the actual anesthesia used there? Is it lidocaine or something like that?

A. Yeah. Typically, in our current practice, we use lidocaine plus or minus epinephrine.

Q. And that's standard for both aspiration and D&E unless the patient has a known allergy. Is that what I heard you say?

A. Yeah, generally, I think that's correct.

Q. Let's move on to the -- well, start at the

pregnancy and certainly with induced abortion as well. It's typically -- it's typically referred to as endometritis after a procedural abortion when we're talking about a infection that's affecting the uterus.

Q. Okay. Would you agree that endometritis, an infection of the uterus, is a possible complication that can arise from an induced abortion?

A. Yes. A very rare one.

Q. Okay. Would you agree that a missed ectopic pregnancy is a complication that can arise when you're providing an induced abortion for a patient?

A. I mean, if -- ectopic pregnancy is a -- is a reality of pregnancy in general. It's not more likely to be associated with induced abortion versus a population of people who aren't seeking an induced abortion.

Q. Okay. The general consensus, I believe, is that 2 percent of pregnant -- positive pregnancies are ectopic pregnancies. Is that correct?

A. I think, depending on the population, the exact point estimate differs, but somewhere between a -- probably a half point -- a half a percent up to three, depending on the population.

Q. And would you agree that a missed ectopic pregnancy, without regard to what the general sort of

prevalence of it is in any given population, that a missed ectopic pregnancy is a potential complication that can arise with providing an induced abortion to a patient?

A. I guess I'm not sure "missed" is the appropriate terminology here. People who come for induced abortion care are assessed for their risk of ectopic pregnancy regardless of what setting I'm working in in order to, you know, try to ensure the person is safe.

Q. If you have a patient who receives -- who you provide a chemical abortion to, and it's actually -- the patient actually has an ectopic pregnancy, do those two drugs that you provide the patient for the chemical abortion have any effect on the ectopic pregnancy?

A. The medicines that we use for medication abortion do not -- are not treatment for an ectopic pregnancy.

Q. So if the patient has an ectopic pregnancy and you are unaware of that and you provide a chemical abortion, that chemical abortion, those drugs, those two drugs that you provide that patient will not stop or end the ectopic pregnancy, will they?

A. So for a person that comes and requests a

medication abortion, we do extensive counseling about the expectations around what they might experience if they take the medicines, but also assess their risk for ectopic pregnancy.

So we certainly wouldn't provide medications for abortion like mifepristone and misoprostol if we thought a person had an ectopic pregnancy.

Q. Right. But sometimes you miss an ectopic pregnancy even if you do screening, right?

A. Sometimes, we're not able to diagnose it because we can't see it.

Q. On an ultrasound, right?

A. If a person has an ultrasound.

Q. So sometimes a patient who comes to you and asks for -- tests positive for pregnancy and asks for a chemical abortion has an ectopic pregnancy that you don't diagnose, and you give that patient the chemical abortion drugs, right?

A. So if someone screens low risk or -- and doesn't have an ultrasound or if a person has an ultrasound and we don't see an ectopic pregnancy, then those people can safely access medication abortion with mifepristone and misoprostol with close follow-up to ensure that the abortion was successful.

Q. But sometimes those people actually have an

ectopic pregnancy even if you think they were low risk or you took an ultrasound and did not locate the pregnancy. Is that correct?

A. Again, for a low-risk population, it's certainly something we discuss with people. But again, because the risk of ectopic pregnancy is so low, it's irrational to not provide the care that the person needs based on that very, very low risk unless that's a risk that's not acceptable to the patient.

Q. And I understand the question you're answering, but it's not really the question I'm asking.

A. Okay. Let me try again.

Q. Yeah. The -- and I appreciate your answer. It's fine. The question I am asking is, sometimes when those patients come to you, even if they are low risk after you screen them and even if you take an ultrasound and you cannot locate the pregnancy anywhere on the ultrasound: intrauterine, adnexa, wherever, sometimes those patients will have an ectopic pregnancy. Sometimes, it's too early to be seen on ultrasound and you just might not see it yet, but sometimes they will have an ectopic pregnancy, right?

A. Some -- a very small percentage of those may

go on to eventually be diagnosed with an ectopic pregnancy, yes.

Q. Okay. And in that situation, if you had a patient who you felt it was safe to give the chemical abortion drugs to even though they slipped through the screening process somehow and actually have an ectopic pregnancy, that particular patient who has ectopic pregnancy and chemical abortion drugs, those chemical abortion drugs don't do anything to stop the ectopic pregnancy, do they?

A. Not that is generally known within the medical community.

Q. Okay. Beyond unstudied and unsubstantiated possibilities, you use methotrexate to actually medically treat an ectopic pregnancy. Is that correct?

A. If a patient comes to me and has a known ectopic pregnancy, then I would -- based on, you know, various patient-level characteristics, I would discuss with that person their options for treatment, which would include expectant management with very close follow-up.

That meaning, you know, watch -- what colloquially people call "watch and wait" with good symptom assessment and, you know, kind of close

follow-up, or medication management with methotrexate typically, or a surgical procedure to treat the ectopic pregnancy.

Q. But in any event, the two chemical abortion drugs don't stop an ectopic pregnancy if they're given to a patient who actually has an ectopic pregnancy. Is that correct?

A. Not that we know.

Q. Okay. You agree that misoprostol has an FDA approval through ten weeks or 70 days. Is that correct?

A. Excuse me, can ---

MS. GRANDIN: Objection to form.

THE WITNESS: Can you say that again?

Q. (Mr. Boyle) Do you agree that the FDA has approved misoprostol through ten weeks or 70 days?

MS. GRANDIN: Objection.

THE WITNESS: Are you saying misoprostol, like m-i-s-o-p-r-o ---

Q. (Mr. Boyle) Mispronouncing that ---

A. Okay.

Q. --- because I have a terrible pronunciation ---

A. Oh, that's okay. I just wanted to make sure that I know what you're saying.

THE COURT REPORTER: Back on the record at 1:52 p.m.

Q. (Mr. Boyle) Okay. So, Doctor, do you have that ACOG Practice Bulletin 193 from March 2018 available?

A. I do. I have it pulled up here in PDF on my computer.

Q. Okay. Do you agree with the -- that ACOG bulletin 193 that, quote, "Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity.

"In 2011 to 2013, ruptured ectopic pregnancy accounted for 2.7 percent of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality," end quote?

A. Gosh, that's a long sentence. If you could point me kind of specifically in the document where you're discussing, then I can ---

Q. Yeah. In the first page, "Background Epidemiology," about halfway through that paragraph.

A. Okay.

Q. "Despite improvements..." Do you agree that that's what the ACOG says on this topic?

A. Yep. That -- what you read there is written

here in that -- in this practice bulletin, yes.

Q. Is that -- and you agree with the ACOG bulletin, right?

MS. GRANDIN: Objection to form.

THE WITNESS: You know, I haven't seen any specific mortality data related to ectopic pregnancy in those specific years, but I know ACOG takes, you know, the production of their practice bulletins very seriously.

Q. (Mr. Boyle) And you rely on these practice bulletins in your practice to provide you with clinical management guidelines, right?

A. As a -- as a starting point, sure. Yeah. Yes.

Q. If you look under -- sorry. If you look under the "Risk Factors" section, do you agree with ACOG that, quote, "Half of all women who receive a diagnosis of ectopic pregnancy do not have any known risk factors," end quote?

A. Yes.

Q. And so a lot of women who actually end up having an ectopic pregnancy don't have flags for known risks for an ectopic pregnancy. Is that correct?

A. Based in their history, not necessarily what's happening in their body currently, yes.

Q. At what stage in pregnancy do you normally screen a woman for an ectopic pregnancy?

A. Well, certainly if I'm taking care of a patient doing their prenatal care visit at 30 weeks, I usually don't discuss ectopic pregnancy at that time. I don't know if you're asking for a specific gestational age week.

I try to assess -- you know, once a pregnant person has had a positive test, a positive pregnancy test, we -- one of the first things we do is talk about how they're feeling in their body and ask about last menstrual period to try to assess an estimated gestational age of the pregnancy.

Q. And so as I understand it, whenever you become aware that your patients has -- patient has tested positive for pregnancy, you consider an ectopic pregnancy as a risk on that patient's differential diagnosis, right?

A. Generally speaking, sure. Yes.

Q. And you screen that patient as soon as you become aware that they're pregnant for ectopic pregnancy immediately, right?

A. I mean, we have -- in all the locations where I work, we have -- we have, you know, kind of general protocols about how to assess somebody's risk

for an ectopic pregnancy. One of which is, you know, just talking about past history, as we've described. The other is to talk about any current signs or symptoms that might be concerning for an ectopic pregnancy.

Q. And the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus inside the uterus. Isn't that right?

MS. GRANDIN: Objection to form.

THE WITNESS: There are, you know, kind of five main categories of early pregnancy. Much of which can rely on ultrasonography.

Q. (Mr. Boyle) Yeah. My question was, the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus seen in the uterus. Isn't that right?

A. The only ---

MS. GRANDIN: Objection to form.

THE WITNESS: The only way to definitively diagnose an ectopic pregnancy is to see an embryo outside of the uterus with ultrasound. It doesn't necessarily have to be a transvaginal one.

Q. (Mr. Boyle) Okay. So you can do a

ultrasound outside the woman's body ---

A. Again, it really -- it really just depends on the patient characteristics. But yes, we, at times, certainly can use transabdominal ultrasonography also.

Q. You said the only time you can definitively diagnose it is when you do the ultrasound and see the ectopic pregnancy. Did I hear you correctly?

A. So what -- if we're using ultrasound in early pregnancy, there are kind of five main diagnoses we could come up with, right? The first is a definite intrauterine pregnancy. The second is a probable intrauterine pregnancy. The third is a pregnancy of unknown location. The fourth is a probable ectopic pregnancy. And the fourth is -- or the fifth, excuse me, the fifth is a definite ectopic pregnancy.

Q. But under those categories, number one, if you do the ultrasound and you see the pregnancy inside the uterus, you've ruled out ectopic pregnancy there, right?

A. In the -- in the vast majority of cases, yes.

Q. You agree that you should always perform an ultrasound on a patient you provide care to when they test positive for pregnancy so that you can confirm if

just the word I chose.

Q. Okay. You're not trying to couch it in terms of the law or the lawsuit when you say irrational?

A. I'm not an attorney, so I don't -- I don't know.

Q. Okay. Were you able to confirm that that patient who you saw at gestational age three weeks was pregnant?

A. (No audible answer)

Q. You mentioned earlier the earliest that you had treated a patient -- a pregnant patient was three weeks gestational age, right?

A. Yes.

Q. How were you able to confirm that patient was three weeks gestational age pregnancy?

A. The patient reported a sure last menstrual period, a history of regular, predictable menstrual cycles that lasted -- that were consistent with, you know, the -- her history of menstrual cycles, so we were able to date the pregnancy that way.

And this particular patient that I'm thinking about also had a urine pregnancy test in our health center.

Q. Did you perform an ultrasound on that

patient?

A. I mean, again, I -- it's my -- it's our standard practice to go through a protocol of history-based screening to determine whether or not we need to recommend an ultrasound for a person.

Q. You agree that induced abortion of any type is more complicated after the unborn child reaches the second trimester, don't you?

A. I'm -- I guess I'm not clear what you're asking.

Q. Complications for induced abortions increase, the risks increase the older the gestational age, so when you get to the second trimester it is more risky to perform an induced abortion in the second trimester than the first trimester. Is that correct?

A. Comparing a procedural abortion in the second trimester to a procedural abortion in the first trimester, yes, the risks are -- the risk, generally, for a procedural abortion increases as the gestation of the pregnancy increases. That would also be true for a person who decided to continue their pregnancy.

Q. Do you agree with the Academy of Medicine's article you cited from extensively when it says that, "The risk of serious complication increases with weeks

gestation. As the number of weeks increase, the invasiveness of the required procedures and the need for deeper levels of sedation also increase"?

A. Again, I'd have to review the specific portion of that document that you're, you know, alluding to to determine whether or not I agree with that. I think, generally speaking, you know, the academy didn't -- yeah, I'll just stop there.

Q. Do you agree with this statement: "The risk of serious complication increases with weeks gestation. As the number of weeks increase, the invasiveness of the required surgical procedure for an abortion and the need for deeper levels of sedation also increase"?

A. That was kind of a lot of things there. So generally, you know, as a person who doesn't -- you know, who recognizes the invasive nature of just having a pelvic exam, I don't -- I don't know exactly what the invasive portion means in that, that you're referring to. But generally, the -- again, for a procedural abortion, as the pregnancy advances, the risk -- the risk can increase.

Q. After 11 weeks gestational age, you don't perform a chemical abortion, right?

A. Not after 77 days.